MIDDLETOWN FAMILY PHARMACY
877 Main St Belford NJ 07718
732.471.9100 732.471.9110 Fax

PATIENT MEDICAL INFORMATION / CONSENT FORM

Please take a few minutes to complete this form. Information provided will be kept confidential and will help your pharmacist in reviewing your medication.

LAST NAME:_____ FIRST: _____ MI: _____

STREET: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ SEX: ____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

PREFERRED CONTACT:	Home	Work	Cell	**Circle One**
PREFERRED METHOD:	Call	Text	E-Mail	**Circle One**

___ I request my prescriptions be placed in a non-child resistant container (valid only if checked)

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES

__ PENICILLINS __ SULFA __ CODEINE OTHER: _____

_____

CONSENT TO ALLOW MIDDLETOWN FAMILY PHARMACY TO USE AND DISCLOSE INFORMATION

1. CONSENT. By signing below, you consent to the use and disclosure of your protected health information by Middletown Family Pharmacy, our staff, and our business associates for treatment, payment, and health care operations.

2. NOTICE OF PRIVACY PRACTICES. You certify that you have received a copy of Middletown Family Pharmacy's Notice of Privacy Practices. You have the right to request the we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make. for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they will be binding on us.

3. RIGHT TO REVOKE CONSENT. You have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

SIGNATURE: _____ DATE: _____